

PUBLIC HEALTH COUNCIL

Meeting of the Public Health Council held Tuesday, November 16, 2004, 10:00 a.m., at the Massachusetts Department of Public Health, 250 Washington Street, Boston, Massachusetts. Public Health Council Members present were: Commissioner Christine C. Ferguson, Chair, Ms. Phyllis Cudmore, Mr. Albert Sherman, Ms. Janet Slemenda (arrived late at 10:30 a.m.), Dr. Thomas Sterne, and Mr. Gaylord Thayer, Jr.. Absent Members were: Mr. Manthala George, Jr., Ms. Maureen Pompeo, and Dr. Martin Williams. Also in attendance was Attorney Donna Levin, General Counsel.

Chair Ferguson announced that notices of the meeting had been filed with the Secretary of the Commonwealth and the Executive Office of Administration and Finance, in accordance with the Massachusetts General Laws, chapter 30A, section 11A ½. Chair Ferguson also announced that the presentation entitled, "Highlights from the Behavioral Risk Factor Surveillance System (BRFSS) has been pulled from the docket.

The following members of the staff appeared before the Council to discuss and advise on matters pertaining to their particular interests: Bela Matyas, M.D., MPH, Medical Director, Immunization Program; Susan Lett, M.D., MPH, Medical Director Immunization Program, Division of Epidemiology and Immunization; Paul Dreyer, PhD, Associate Commissioner, Center for Quality Assurance and Control; and Deputy General Counsel, Sondra Korman, Office of the General Counsel.

RECORDS:

After consideration, upon motion made and duly seconded, it was voted (unanimously) [Ms. Slemenda not present to vote] to approve the Records of the Public Health Council Meeting of September 21, 2004.

In letters dated November 5, 2004, Val W. Slayton, MD, MPP, Director of Medical Services, Tewksbury Hospital, Tewksbury, recommended approval of an appointment and reappointments to the various medical and allied health staffs of Tewksbury Hospital. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously) [Ms. Slemenda not present to vote]: That, in accordance with recommendation of the Director of Medical Services of Tewksbury Hospital, under the authority of the Massachusetts General Laws, chapter 17, section 6, the following appointment for the period of November 1, 2004 through December 31, 2004 and reappointments to the various medical and allied health staffs of Tewksbury Hospital be approved for a period of two years beginning November 1, 2004 to November 1, 2006:

<u>APPOINTMENT:</u>	<u>MASS. LICENSE NO.:</u>	<u>STATUS/SPECIALTY:</u>
Andrew Aldridge MD (11/1/04-12/31/04)	76759	Provisional Active Psychiatry
<u>REAPPOINTMENTS:</u>	<u>MASS. LICENSE NO.:</u>	<u>STATUS/SPECIALTY:</u>
Julieta Austria, MD	51406	Active Internal Medicine
Daniel Hallissy, DPM	2135	Consultant Podiatry

David Sidebottom, MD	48047	Consultant Infectious Disease
Bette Ippolito, PhD	6572	Allied Psychologist

In a letter dated, November 8, 2004, Paul Romary, Executive Director, Lemuel Shattuck Hospital, Jamaica Plain, recommended approval of the appointments and reappointments to the various medical staffs of Lemuel Shattuck Hospital. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously) [Ms. Slemenda not present to vote]: That, in accordance with recommendation of the Executive Director of Lemuel Shattuck Hospital, under the authority of the Massachusetts General Laws, chapter 17, section 6, the following appointments and reappointments to the various medical staffs of Lemuel Shattuck Hospital be approved:

<u>APPOINTMENTS:</u>	<u>MASS. LICENSE NO.:</u>	<u>STATUS/SPECIALTY:</u>
Omayra Nieves, MD	221002	Consultant/Psychiatry
Iva Pravdova, MD	161099	Consultant/Psychiatry
Betty Wang, MD	220545	Consultant/Psychiatry
Maxim Lianski, MD	222895	Consultant/Psychiatry
Michele Allen, MD	220319	Consultant/Psychiatry
<u>REAPPOINTMENTS:</u>	<u>MASS. LICENSE NO.:</u>	<u>STATUS/SPECIALTY:</u>
Daniel Weiner, MD	213380	Consultant/Internal Medicine
Salin Dahlben, MD	45299	Active/Psychiatry
Daniel Naiman, MD	45442	Active/Psychiatry
Thomas Posever, MD	53630	Active/Psychiatry
Maryanne Carrazza, DMD	14610	Active/Dentistry
Leonid Kotkin, MD	151270	Active/Urology

For the Record, Council Member Janet Slemenda arrived late at approximately 10:30 a.m. during the medical malpractice payments presentation below.

STAFF PRESENTATION: "Special Report on Medical Malpractice Payments: 1994-2003",
by Nancy Achin Audesse, Executive Director, Board of Registration in Medicine

Ms. Achin Audesse made a slide presentation before the Council. Some statistical highlights follow:

- The number of physicians making payments from 1994-2003 increased by 5% over 1990-1999, from 2,183 to 2,307.
- During this time the total number of physicians remained fairly constant.
- The percentage of physicians making payments increased from 5.4% to 6.17%.

- Regardless of specialty, age and gender are very significantly related to number of payments.
- Only 98 physicians, or 4.2% of the 2,307 physicians who made a payment, and one quarter of one percent of all physicians, had more than two paid claims.
- These 98 physicians, however, were responsible for 388, or 13.5%, of all paid claims, and \$133,988,105 or 12.9%, of all dollars paid.
- Of the 98 physicians, 50 remain in practice, of whom 9 have been disciplined by the Board. The remaining 48 were removed from practice by Board action, retired, allowed their licenses to lapse, are inactive or are deceased.
- The three specialties with the most paid claims are still Obstetrics & Gynecology, Internal Medicine and General Surgery.
- The three specialties with the highest percentage of physicians making payments are still Gynecology, Obstetrics/Gynecology and Neurological Surgery. Note: two specialties with fewer than 100 physicians have higher percentages, but the small number of physicians and payments make percentages unreliable.

The results of the data analysis of the ten-year period from 1994-2003 are remarkably similar to the 1990-1999 results. The same medical specialties were identified as most highly correlated to malpractice payments. Again, most physicians had no malpractice payments; among physicians reporting a paid claim, the overwhelming majority had only a single paid claim:

- Total aggregated payments over the 1994 to 2003 period were \$1,035,453,336, an increase of 27% over 1990-1999.
- Total annual payments from 1994 to 2003, however, grew by 85.3%. Even adjusted for inflation, annual payments jumped 50%.
- Annual payments peaked in 2001 at \$129,095,469. Since then payments have dropped by 7.8%.
- Total aggregated number of payments from 1994 to 2003 rose 4%, from 2,766 to 2,876.
- The annual number of payments from 1994 to 2003 grew by 8.2%.
- Annual payments peaked at 332 in 2001, and have since declined by nearly 17%.
- Over the 10-year period the average payment was \$360,000. In 2003 the average was \$431,016.
- In 2001 the average payment in the U.S. was approximately \$300,000. In Massachusetts it was \$388,841.

- The number of payments over \$1,000,000 grew from 163 or 5.9% of all payments to 244, or 8.5% of all payments (a 50% increase).
- Payments ranging from \$500,000 to \$1,000,000 rose from 368 to 455, a 19% increase.
- Payments under \$100,000 dropped from 1,013 (36.6% total) to 841 (29%).
- Only 57 (2%) of the 2,876 malpractice payments were the result of a jury verdict, but jury verdicts are strongly related to higher payment amounts.
- The average jury award from 1994-2003 in Massachusetts was \$976,147. The average jury award nationally in 2001 was about \$500,000.
- There is no significant relationship between board certification and the incidence of malpractice payments.
- There is no significant relationship between paid claims and whether a physician graduated from a domestic or international medical school.
- A relationship between physicians' years of experience and paid claims is difficult to demonstrate statistically. Years of experience is so closely related to age that the correlation values become unstable and of no use.

During the period from January 1, 1994 to December 31, 2003, the total physician population in Massachusetts included 37,369 individual practitioners, down 7.6% from the period 1990-1999. For comparison, in October 2004 the total number of active physicians was 31,080:

- The gender mix of physicians in 2003 was 68.6% male and 31.4% female. This marks an increase in the proportion of women of over 5 percentage points from 1990-1999.
- 80% of this population graduated from U.S. or Canadian medical schools, while 20% graduated from international medical schools. This is roughly equivalent to 1990-1999.
- 75% were board certified in at least one specialty.
- 98% of the active physicians were Medical Doctors (M.D. degree) and 2% were Osteopathic Doctors (D.O. degree).

Conclusions and Recommendations:

The report concluded: "An encouraging finding of this report is that, since 2001, the number of malpractice payments made annually has declined, as has the value of those payments. In contrast, the number of physicians being sued for malpractice continues to increase, as does the size of individual payments made and the percentage of the overall physician population making them. Furthermore, certain specialties continue to be affected more than others. The average pediatric surgery malpractice payment, for example, is three times the average general surgery

award. From 1994 to 2003 nearly 1 in 4 obstetrics/gynecology specialists made a malpractice payment, as did 1 in 5 gynecologists and 1 in 6 neurosurgeons. And those are just the physicians making a payment. The number being sued, and defending their skills and livelihoods, is considerably higher.

Every malpractice suit is the result of a real or perceived adverse patient outcome. But what is the cause of those adverse outcomes? As this and a previous Board report on medical malpractice payments demonstrate, there is no direct cause and effect relationship between any given malpractice payment and the practice of good medicine, but clearly clinical competence accounts for some proportion of malpractice cases. And what other factors are at work? More importantly, what policies and procedures can be put in place to address both clinical skills and the other factors driving malpractice suits and awards?

The insurance industry, the physician community and others have made a variety of recommendations for reforming the medical malpractice system. Some have been proposed in Massachusetts and elsewhere, some have in fact been adopted in other states:

- Cap amounts awarded for non-economic damages
- Establish expert medical courts
- Limit the amount paid to attorneys
- Pay large awards over time rather than in a lump sum
- Reduce awards by amounts collected from collateral sources
- Eliminate joint and several liability

All of these proposals are worth serious and thoughtful consideration by lawmakers, and debate on them is welcome. That debate, however, will occur mostly in the halls of government. Other proposals, those to reduce the incidence of actual medical malpractice in the first place, can be debated – and adopted – in the halls of hospitals and other health care facilities, as well as by the Board. The Board’s primary responsibility is patient safety, and so this report focuses on proposals whose effects will be felt before a malpractice event ever happens.

NO VOTE/INFORMATION ONLY

MISCELLANEOUS: ADOPTION OF THE FINAL AGENCY DECISION IN THE MATTER OF DEPARTMENT OF PUBLIC HEALTH, OFFICE OF EMERGENCY MEDICAL SERVICES V. STEVEN DESROSIERS:

Attorney Sondra M. Korman, Deputy General Counsel, Department of Public Health, presented the matter of the Department of Public Health, Office of Emergency Medical Services v. Steven Desrosiers before the Council for final action. Atty. Korman noted, “...In November of 2003, the Office of Emergency Medical Services (OEMS) brought an agency action against EMT Paramedic

Steven Desrosiers (Desrosiers) to temporarily revoke his EMT certification for a minimum of thirty (30) days and until he completes specified remedial training. Desrosiers elected to appeal the action and the matter was referred to DALA for an evidentiary hearing. After three days of hearing testimony, the Magistrate issued a recommended decision, and found the proposed action was warranted by the evidence. Under the rules governing administrative actions like this, the Magistrate's decision does not become a final decision unless the Public Health Council takes action to adopt it as the final decision of the agency. Staff recommends that the Commissioner and Public Health Council affirm and adopt the recommended final decision of the Magistrate as the final decision of the Department of Public Health."

It was noted that the Department is authorized by M.G.L.c.111C, §2,3 to regulate ambulance services, EMTs and the provision of pre-hospital emergency care in the Commonwealth. The Department's regulations, 105 CMR 170.900-941, govern the certification of EMTs. Under these regulations, the Department is authorized to issue EMT certifications to qualified applicants who have successfully completed the required education and training programs. Additionally, the regulations authorize the Department to impose sanctions including revocation or suspension of an EMT certification, for reasons set forth in 105 CMR 170.940.

Atty. Korman noted further, "In this case, the Department conducted an investigation of alleged poor quality of care during a July 13, 2004 emergency response in which Desrosiers and his partner, a new EMT-Paramedic, were dispatched to a nursing home for a patient in respiratory distress. The investigation report determined that the allegation was valid in that the ambulance remained on the scene for 29 minutes and failed to transport the patient to a hospital just minutes away from the nursing home (2.9 miles) contrary to the governing Statewide Treatment Protocols. Instead of initiating immediate transport to the hospital, Desrosiers attempted to perform repeated endotracheal intubations on the patient, with no success. In addition, Desrosiers initiated at least one additional intubation attempt even after receiving a Medical Control physician order directing that the patient be transported to the hospital."

Atty. Korman continued, "After three days of hearing witness testimony, the Magistrate made findings of fact and conclusions of law. In sum, the Magistrate found that: Desrosiers violated the standard of care because he (1) failed to follow the directives of the relevant treatment protocols to "initiate transport as soon as possible"; (2) failed to comply immediately with the second order of Medical Control to "bag and go"; (3) made repeated and unsuccessful attempts to intubate the patient rather than transport him immediately to the hospital; and (4) drove the ambulance to the hospital, leaving the patient with an inexperienced paramedic, when he could have easily remained with the patient and allowed an EMT-Basic to drive. During the hearing, Desrosiers disputed the evidence offered by the Department, including eyewitness testimony given by the EMT-Basics as well as the testimony of the Department's Surveyor as to Desrosiers' interview statements. In making her rulings, the Magistrate made credibility findings in favor of the Department's witnesses. She did not credit Desrosiers' version of the events. The Magistrate concluded that Desrosiers' actions constituted a 'failure to exercise reasonable care, judgment, knowledge, or ability in the performance of his duties or to perform those duties within the scope of this training and certification and in accordance with the Statewide Treatment protocols.' The Magistrate also found that that his actions constituted 'gross misconduct', 'endangered the health and safety of the public', and constituted a 'refusal to transport a patient to an appropriate health care facility in an emergency.'" In

sum, the Magistrate concluded that the proposed sanction ‘is reasonable in light of the Respondent’s lack of good judgment and refusal to take responsibility for his actions.’

Atty. Korman stated further, “Desrosiers has a disciplinary history with the Department. In 1998, OEMS temporarily revoked his EMT certification and required him to undergo remedial training for this actions at the scene of a major motor vehicle crash. In that case, Desrosiers attempted to intubate a patient when he was not certified to perform that, or any other, ALS skill. Desrosiers did not contest the 1998 enforcement action...”

A lengthy discussion followed by the Council. The Council had concerns about Desrosiers’ clinical judgment and instructed staff to include clinical judgment in the remedial training program (additions from Council meeting are in bold and underlined below). For the record, Council Member Sherman left the meeting during discussion of this matter at approximately 11:15 a.m.; therefore he did not vote on this or docket items 5a and 5b.

After consideration, upon motion made and duly seconded, it was voted: (unanimously)[Mr. Sherman not present to vote] to approve and **Adopt the Final Agency Decision in the Matter of Department of Public Health, Office of Emergency Medical Services v. Steven Desrosiers; that Desrosiers’ EMT certification, at all levels, be revoked for a minimum of thirty (30) days.** This revocation will not terminate until Respondent has completed a remedial training program with oversight by the Affiliate Hospital Medical Director (tied to the Ambulance Service for which Desrosiers works). The remedial training program is outlined below:

1. Respondent shall complete a remedial training program consisting of: (a) review of Statewide Treatment Protocols; (b) review of state regulations governing pre-hospital emergency procedures; (c) review of legal aspects of documentation; **(d) review of appropriate clinical judgement.**
2. Respondent shall submit a description of the remedial training program, including the dates, times, locations and instructors, to the Department for prior approval.
3. Upon the Department’s approval, Respondent shall participate in such remedial training program with oversight by the affiliate hospital medical director or his/her designee (“the oversight medical director”).
4. Respondent shall submit documentation evidencing successful completion of such remedial training program. In addition, the oversight medical director shall submit documentation attesting to Respondent’s skills and competency in intubation and administration of medication; **and Respondent’s use of appropriate clinical judgment.**

The Respondent, Stephen Desrosiers did not appear at the Public Health Council meeting, nor did his Counsel. However a letter dated November 9, 2004 and received by the Department on November 12, 2004 was handed out to the Council Members at the start of the meeting from the respondent stating, “Please regard this letter as official notification of my appeal in accordance with the provisions of 801 CMR 1.01 (11) (c) (1) and will be received within the time limit. The basis of

my appeal is on the factual inaccuracies found in the DALA decision in accordance with the testimony given.”

PROPOSED REGULATIONS:

INFORMATIONAL BRIEFING ON 105 CMR 220.000: IMMUNIZATION OF STUDENTS BEFORE ADMISSION TO SCHOOL; AND 105 CMR 221.000: PROMOTING AWARENESS OF MENINGOCOCCAL DISEASE AND VACCINE:

Dr. Susan Lett, and Dr. Bela Matyas, presented the proposed regulations to the Council. Dr. Lett presented the 105 CMR 220.000 and Dr. Matyas presented 105 CMR 221.000. Dr. Lett said in part, “...The Department has been mandated by an amendment to M.G.L. Ch.76,§15D to promulgate regulations to ensure that all newly enrolled full and part-time students at secondary schools and colleges which provide or license housing must: (1) receive information about meningococcal disease and vaccine; and (2) provide documentation of meningococcal vaccination or qualify for one of the exemptions to immunization established by the statute. The statutory language applies to all new students at these institutions (even if they do not reside in dormitories or institution-provided housing). The law further states that affected institutions are not required to provide the vaccine or incur the expense of the vaccine. In contrast to other statutes regarding immunization requirements, this law contains an exemption for students signing a waiver refusing vaccination. It also directs MDPH to develop a waiver form, which must include information about the risks and dangers of meningococcal disease and to promulgate regulations that will become effective in August 2005...”

In response to the legislation, staff has drafted amendments to 105 CMR 220.000. All of the language pertaining to these new requirements has been organized into a new section, 105 CMR 220.700. The proposed amendments are summarized below:

1. Definitions

- **Secondary School:** A secondary school is a school or that part of the school that provides education for students in grades 9 through 12.
- **Postsecondary Institution:** Postsecondary institution has been defined in 105 CMR 220.600 and this definition is unchanged.
- **Students:** For the purposes of 105 CMR 220.700, students shall mean:
 - a) Students newly enrolled at a secondary school that provides or licenses housing; and
 - b) Full-time and part-time undergraduate and graduate students newly enrolled in a degree granting program at a postsecondary institution that provides or licenses housing.

Requirements

- **Institutional requirements:** Secondary and postsecondary institutions that provide or license housing must provide each newly enrolled student with detailed information

about the risks associated with meningococcal disease and the availability and effectiveness of vaccines against the disease, if he or she is at least 18 years old (or to the student's parents or guardian, if the student is a minor).

- **Student Requirements:** Newly-enrolled students must provide written documentation that they have received meningococcal vaccine within the last 5 years, unless they have a medical or religious exemption or have signed a waiver declining the vaccine.
- **Exemptions:** Students may begin classes without a certificate of immunization against meningococcal disease if: (1) the student has a letter from a physician stating that there is a medical reason why he/she can't receive the vaccine; (2) the student (or the student's parent or legal guardian, if the student is a minor) presents a statement in writing that such vaccination is against his/her sincere religious belief; or (3) the student (or the student's parent or legal guardian, if the student is a minor) signs a waiver stating that the student has received information about the dangers of meningococcal disease, reviewed the information provided and elected to decline the vaccine.

2. **Waiver:** MDPH staff has drafted a form entitled, 'Information about Meningococcal Disease and Vaccination and Waiver for Students at Colleges and Secondary Schools. It contains information about the dangers of meningococcal disease and the benefits and risks of meningococcal vaccine. It states that students (or parent or legal guardian) must show proof of meningococcal vaccination or fall within one of the exemptions provided in the law. The waiver section of the form states that the student (or parent/legal guardian) has reviewed the information provided and chooses to waive receipt of meningococcal vaccine.

Dr. Matyas, presented 105 CMR 221.000 to the Council. He noted in part, "The Department has also been mandated by M.G.L.c.111, s.219 to establish regulations requiring all public and private secondary schools, public and private colleges and universities, day care centers and youth camps to distribute to the parent or guardian of any child in their care, or to the student or attendee if 18 years of age or older, information regarding the risk of meningococcal disease and the effectiveness and risk of meningococcal vaccine. The new regulation provides for definitions for 'secondary school', 'day care center' and 'youth camp', and requires dissemination of information about meningococcal disease and vaccine in accordance with c.111, s.219."

Council discussion followed whereby it was noted that perhaps the legislation should be fine-tuned so that the requirements should only apply to students living in dormitories. The waiver form was also discussed. Dr. Sterne said, "One other thing we can do is alter the wording of the waiver. I would think that that is within regulatory bounds. And if in fact that is so, we can structure the language in the waiver so as to read that this vaccine has proved to be a benefit, clearly for people who are living in dormitories, in close proximity to each other on campus. And that may give more people pause to actually go through with the vaccine, and the waiver at the bottom should also be non-judgemental. You should have to have a religious belief etc. There should be a line item on the waiver that says, for other reasons, I choose not to receive the vaccine at this time. I understand that I will not be living in a dormitory, or something like that. And if we have any rights with regards to the structure of the waiver, I think that it is within the Council's purview to make a recommendation about the content....adding a sentence or two that

makes it clear about who is most likely to benefit from the vaccine will add educational value to anyone reading the waiver.” Chair Ferguson asked staff to work on the waiver.

NO VOTE/INFORMATION ONLY

REGULATIONS:

REQUEST FOR PROMULGATION OF PROPOSED AMENDMENTS TO HOSPITAL LICENSURE REGULATIONS GOVERNING THE DESIGNATION OF TRAUMA CENTERS (105 CMR 130.851):

Dr. Paul Dreyer, Associate Commissioner, Center for Quality Assurance and Control, presented 105 CMR 130.851 to the Council. He said in part, “The purpose of the proposed amendment is to revise previously-prescribed timelines for hospital designation as a trauma center. Last February, the Department adopted regulations governing the designation of trauma centers. The primary criterion for designation was verification by the American College of Surgeons (ACS); that is, hospitals that successfully completed the ACS process and received formal verification met one of the criteria for designation as a trauma center. As the staff in the Center worked to implement the regulations, it became apparent that the timelines set out for ACS verification are not feasible. In particular, the ACS will not accept formal applications for verification until it has reviewed nine months of trauma data. This policy makes it virtually impossible for any hospital not already well into the ACS verification process to meet the timelines that were contained in the regulation. The proposed amendment removes the explicit timelines from the regulation, and allows the Department to set out in guidelines the timeframes for ACS verification that hospitals must meet in order to be designated as trauma centers. It also removes an incorrect reference to ‘system hospital’ and instead refers to hospitals that are not Designated Trauma Centers. A public hearing had been held on October 19, 2004. No one offered oral testimony at the hearing, nor did the Department receive any written comments on the proposed amendment. The Department asks that you approve the amendment for promulgation.”

After consideration, upon motion made and duly seconded, it was voted: (unanimously) [Mr. Sherman not present to vote] to approve **Promulgation of Proposed Amendments to Hospital Licensure Regulations Governing the Designation of Trauma Centers (105 CMR 130.851)**; that a copy of the approved amendments be forwarded to the Secretary of the Commonwealth for promulgation; and that a copy be attached and made a part of this record as **Exhibit No. 14,796**. The amendment will become effective upon publication in the Massachusetts Register on December 3, 2004.

REQUEST TO PROMULGATE PROPOSED AMENDMENTS TO 105 CMR 172.000, IMPLEMENTATION OF M.G.L.c.111,§111C, REGULATING THE REPORTING OF INFECTIOUS DISEASES DANGEROUS TO THE PUBLIC HEALTH:

Dr. Paul Dreyer, Associate Commissioner, Center for Quality Assurance and Control, presented proposed amendments to 105 CMR 172.000 to the Council. Dr. Dreyer noted, “...The Department is charged with promulgating regulations that define ‘infectious diseases dangerous to the public health’. Pursuant to this authority, the Department previously promulgated 105

CMR 172.000. In addition to defining those diseases, the regulation provides that EMS workers receive notification via a designated infection control officer at their ambulance services, emergency first response (EFR) services, or first responder agencies. The regulation also sets forth a means by which a health care facility will notify the infection control officer at the service or agency if a patient is diagnosed with an airborne or other infectious disease to which an EMS worker was exposed. In its current form, the regulation lists those diseases that were determined to be dangerous to the public health for the notification purposes of section 111C as of July 2003. The Department now proposes to add several other diseases to the list. Additionally, the Department is proposing to add a new section to the regulation, similar to 105 CMR 300.150, which appears in 105 CMR 300.000, Reportable Diseases, Surveillance, and Isolation and Quarantine Requirements. This new section will permit the Department to immediately add a new disease to the list, but only for a maximum period of twelve months. This will enable the Department to act quickly in the event that a new disease, like SARS, appears, but also guarantees that within twelve months of such action the Department must comply with the procedural requirements of M.G.L.c.30A, including holding a public hearing, to permanently amend the regulation.”

Dr. Dreyer continued, “The proposed amendments will add Severe Acute Respiratory Syndrome (SARS), smallpox, monkeypox and infection with any other orthopox virus in humans (including vaccinia) to the list of infectious diseases in the regulation. Additionally, the amendments will provide that the Commissioner of Public Health may declare other newly recognized or recently identified infectious diseases as infectious diseases dangerous to the public health and subject to the provisions of 105 CMR 172.000 for a period of time not to exceed 12 months. The Department held a public hearing on October 19, 2004. No one offered oral testimony at the hearing, nor did the Department receive any written comments on the proposed amendments. Staff asks that you approve the amendments for promulgation.”

After consideration, upon motion made and duly seconded, it was voted: (unanimously)[Mr. Sherman not present to vote] to approve the request to **Promulgate Proposed Amendments to 105 CMR 172.000, Implementation of M.G.L.c.111, §111C, Reporting of Infectious Disease Dangerous to the Public Health;** that a copy be forwarded to the Secretary of the Commonwealth for promulgation; and that a copy be attached and made a part of this record as **Exhibit No. 14,797.** The amendments will become effective upon publication in the Massachusetts Register on December 3, 2004.

The meeting adjourned at 11:50 a.m.

Christine C. Ferguson
Chair

LMH/lmh